

South Carolina Department of Disabilities and Special Needs

Report of Alleged Abuse, Neglect, or Exploitation

ADDENDUM TO: ☐ Administrative Review ☐ Management Review ☐ Reinstatement Request
Provide brief summarized information only in this report (additional sheets may be attached, if necessary)

This form should be submitted:

- when information on the Administrative Review or Management Review has changed or additional information needs to be provided after the review has been conducted,
- due to any change to the disposition of the case,
- when information pertaining to the results of outside agency investigations was received after the Administrative or Management Review was submitted
- to report the Provider's completion of recommendations made in writing by the Ombudsman's Office,
- due to changes regarding the status of employment/personnel action taken,
- in all instances where the Reinstatement Request has been approved or disapproved.

Provider Agency:

Name(s):	1. Victim:	Perpetrator:
	2. Victim:	Perpetrator:
	3. Victim:	Perpetrator:
	4. Victim:	Perpetrator:

Date of Incident: _____

If Date of Incident is unknown, indicate Date Incident Reported (also shown on Initial Report): _____

REASON FOR ADDENDUM

Brief explanation as to why Addendum is being submitted: _____

- | | |
|--|--|
| <input type="checkbox"/> Change in Final Disposition: | <input type="checkbox"/> Substantiated/Founded (Perpetrator Known) |
| | <input type="checkbox"/> Substantiated/Founded (Perpetrator Unknown) |
| | <input type="checkbox"/> Unsubstantiated/Unfounded <input type="checkbox"/> Other Agency Investigating |
| <input type="checkbox"/> Change in Outcome: To: _____ | |
| <input type="checkbox"/> Reinstatement of Employee | Indicate date employee returned to work: _____ |
| <input type="checkbox"/> Employee Grievance | <input type="checkbox"/> Termination of Employee |
| <input type="checkbox"/> Employee Resigned or No Longer Works for Agency | |
| <input type="checkbox"/> Result of Outside Investigation | <input type="checkbox"/> Result of Internal Review/Investigation |
| <input type="checkbox"/> Re-opened Investigation | <input type="checkbox"/> Result of Law Enforcement Investigation |
| <input type="checkbox"/> Other (Explain): _____ | |

Indicate other investigative agency(ies) and that agency's Intake # _____ or Case ID # where applicable :

Comments: _____

FINAL ACTION

SIGNATURE

Executive Director/CEO/Facility Administrator
Executive

Date

Name of Person Completing Form (or Designee for
Director/CEO/Facility Administrator)

*Send completed form within 24 hours or the next business day as a separate report (not to be included with Initial Report or Review) to:
Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, FAX: (803)898.7450*

534-02-DD

Attachment F (Revised 01/31/14)